PHYSICIAN-PATIENT RELATIONSHIP
FINDINGS AND RECOMMENDATIONS

I. FINDINGS

The physician-patient relationship is fundamental to health care delivery. Cardinal Bernardin, in a statement given to the American Medical Association House of Delegates in 1995, shortly before his death from pancreatic cancer, described the physician-patient relationship as a covenant. He stated:

> The moral center of the doctor-patient relationship is the very essence of being a doctor. It also defines the outlines of the covenant that exists between physicians and their patients, their profession, and their society. The covenant is a promise that the profession makes – a solemn promise – that it is and will remain true to its moral center. In individual terms, the covenant is the basis on which patients trust their doctors. In social terms, the covenant is the grounds for the public's continued respect and reliance on the profession of medicine.[1]

Although the effects are inherently difficult to study, beneficial relationships between physician and patient have been shown to decrease and/or shorten hospitalizations, lower utilization of resources, enhance compliance, and improve satisfaction among patients and physicians.[2,3,5] There is also some evidence about the impact of external factors on the physician-patient relationship: that the availability of a choice of health plans increases patients' satisfaction with their physicians.[4]

Views of physicians and patients, as well as physician-patient relationships have evolved over time. Recently, however, the nature of the physician-patient relationship has changed. The increased presence of third-party payers in the health care system over the last 30 years has eroded the trust between physician and patient.[5] Managed care has added sources of doubt. Important factors that appear to have contributed to this decline in trust include issues related to: (a) continuity with physicians, (b) the gatekeeper role of primary care physician and utilization review, (c) informing patients of all options, (d) financial incentives, (e) physician availability, and (f) quality improvement programs.

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[1] Cardinal Bernardin J, "Renewing the Covenant with Patients and Society", Address to AMA House of Delegates, Washington, DC, December 5, 1995.

[2] Weiss L and Blustein J, "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on Costs and Use of Health Care by Older Americans", *American Journal of Public Health*, 86:12, December 1996, 1742-1747.

[3] Brody DS, et al., "Patient Perception of Involvement in Medicare Care: Relationship to Illness Attitudes and Outcomes", *Journal of General Internal Medicine*, 4, November/December, 1989, 506-511. Also see Greenfield S, et al., "Expanding Patient Involvement in Care: Effects on Patient Outcomes", *Annals of Internal Medicine*, 102, 1985, 520-528 and Greenfield S, et al., "Patients' Participation in Medical Care: Effects on Blood Sugar Control and Quality of Life in Diabetes", *Journal of General Internal Medicine*, 3, Sept/Oct, 1988, 448-457.

[4] Davis K, "Employees Lack Options Among Health Plans", The Commonwealth Fund, August 1997.

[5] Gray B, "Trust and Trustworthy Care in The Managed Care In The Managed Care Era", *Health Affairs*, 16:1, January/February 1997, 34-49; and Gray B, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*, Cambridge: Harvard University Press, 1991.

A. Continuity with Physician

A continuous relationship with a physician provides familiarity with patient medical histories. As a result, doctors can react quickly in emergencies, make knowledgeable decisions, and handle many situations on the telephone. In addition, studies have shown that patients staying with the same physician for long periods are less likely to be hospitalized, more likely to have lower costs, and to be more satisfied.[6] Many HMOs attempt to formalize this relationship through the designation of primary care physicians (PCPs). Several features of HMOs, however, tend to make continuity of care difficult to maintain. These include closed HMO panels, termination of physician contracts, changes in coverage by employers, and lack of choice and information.

B. Gatekeeper Role of Primary Care Physician and Utilization Review

An additional factor affecting the physician-patient relationship is the "gatekeeper" role of primary care physician and utilization review. The model is based on the United Kingdom's general practitioner with the intent of improving quality and reducing costs by coordinating care through one provider. Although studies have shown that as many as 30% of procedures are medically unnecessary,[7] denying access to care–whether necessary or not–strains the physician-patient relationship.[8] Conflict may result when physicians control referrals to specialists,[9,10] referrals to procedures,[11] and referrals to care outside the HMO network.

C. Informing Patients of All Options

Managed care expects patients to play a more participatory role in their care. Thus, under managed care, patient access to more and better information for patients is appropriate and necessary. Physicians should help patients to make informed decisions based on the advantages and disadvantages of each option and the patient's personal preferences. Although "gag clauses" have been banned in California and management guidelines are generally intended as recommendations, there is still some fear that improper discussion or behavior may result in contract termination by the health care plan.[12] In addition, the current system lacks a systematic

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[6] Weiss LJ, Blustein J, "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans", *American Journal of Public Health*, Volume 86, pp. 1742-7, 1996; and Blumenthal, D, et al;, "The Efficacy of Primary Care for Vulnerable and Other Population Groups", *Health Services Research*, 30, 1995, 253-273.

[7] Sui AL, et al., "Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans", *The New England Journal of Medicine*, November 13, 1986, 1259-1266; Chassin MR, et al., "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? A Study of Three Procedures", *Journal of the American Medical Assocation*, November 13, 1987, 2533-2537; and Winslow DM, et al., "The Appropriateness of Performing Coronary Artery Bypass Surgery", *Jounral of the American Medical Association*, July 22, 1988, 505-509.

[8] Blumenthal, D, "Effects of Market Reforms on Doctors and Their Patients", *Health Affairs*, Summer 1996, 170-184.

[9] Op-Cit., Blumenthal, D, 1996; and Ayanian JZ, et al., "Knowledge and Practices of Generalist and Specialist Physicians Regarding Drug Therapy for Acute Myocardial Infarction", *The New England Journal of Medicine*, 318:20, 1988, 1310-1314.

[10] Center for Studying Health System Change and Mathematica Policy Research Inc., nationwide survey of physicians.

[11] Mechanic D, Schlesinger M, "The Impact of Managed Care on Patient's Trust in Medical Care and Their Physicians," *JAMA*, 275:21, June 5, 1996, 1693-97.

[12] US General Accounting Office, "Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, But Physician Concerns Remain" (GAO/HEHS-97-175), August 1997.

mechanism for assessing and informing patients about the experience and competence of their health care delivery system and personal physician.[13]

D. Financial Incentives

While physicians are motivated principally by professional ethics and desire for the esteem of their peers, they also face financial incentives. All compensation arrangements contain incentives which may have positive and negative effects. An important issue is whether or not patients have access to information about how their medical care is paid for (see Provider Financial Incentives paper). Several forms of compensation arrangements in managed care, including capitation and risk pools, shift financial risk for caring for patients to providers. Although this structure creates incentives for physicians to limit unnecessary care and reduce costs, it also has the potential to reward physicians for denying medically appropriate care. This form of reimbursement may also reduce patient satisfaction and erode trust between patients and physicians.[14]

E. Physician Availability

When people are sick, they want to see their doctor and expect their doctor to be available; they want appointments to be available within a reasonable time frame, and to be long enough for evaluation and treatment.[15] Adequate physician availability can prevent miscommunication, non-communication, disputes, and grievances. Current law requires Knox-Keene regulated health plans to restrict physician panels to 2,000 patients per PCP.[16] Availability, however, may depend on the skill of the physician and the health patient panel. To reduce costs, managed care organizations often replace physicians with less expensive physician extenders such as nurse practitioners.[17] Physician extenders offer increased access at lower costs and may demonstrate better communication skills than physicians, but make coordination and oversight more difficult. Doctor visits have both medical and emotional impact. Shorter visits that may be medically acceptable can still be a source of patient dissatisfaction.

F. Quality Improvement Programs

Purchasers have largely driven quality measurement and improvement efforts. While not universal and still under development, these quality measurement efforts offer feedback to providers to improve and information to purchasers and consumers to judge quality and service. Quality improvement programs have resulted in increased paperwork which requires the investment of significant time and effort, the benefits of which may not be readily apparent to those required to provide the data. Several experts have noted that trust in physicians' decisions is increasingly supplemented by evidence such as that provided by disclosure of quality improvement and measurement results.[18]

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[13] Ezekiel EJ and Dubler NN, "Preserving the Physician-Patient Relationship in the Era of Managed Care," *JAMA*, 273:4, January 25, 1995, 323-329.
[14] Op-Cit., Blumenthal, D, 1996.
[15] California Public Employees' Retirement System, *1995 Open Enrollment Exit Survey: Final Report for Basic Health Plans*, Sacramento, CA, April 16, 1996.
[16] Item H(i) Primary Care Providers in Commissioner's Rule 1300.51(d) in Title 10, California Code of Regulations.
[17] Felt-Lisk S, "How HMOs Structure Primary Care Delivery," *Managed Care Quarterly*, 1996; 4(4), 96-105.
[18] Op Cit., Gray B, "Trust and Trustworthy Care" 1997.

II. RECOMMENDATIONS

A guiding principal for the recommendations of this Task Force and health care system change in general should be an evaluation of the effect of the proposed change on the physician-patient relationship.

A. Continuity with Physicians

In addition to recommendations in the Consumer Information, Communication and Involvement paper regarding disclosure and presentation of information about provider availability, the following recommendations could further address continuity issues:

1. The regulatory authority should require health plans and medical group/IPAs to write contractual arrangements that enable members such as those chronically ill, acutely ill, and pregnant to continue seeing their doctors until the end of the patients' contract year and no less than a minimum period such as 60 days or through completion of post-partum care.

In addition, there may also be an issue regarding whether or not plans should be required to provide a reason for non-renewal of a provider's contract without cause.

B. 'Gatekeeper' Role of Primary Care Physician and Utilization Review

In addition to recommendations in the Medical Necessity paper regarding modification of prior authorization procedures and in the Dispute Resolution paper regarding disclosure and procedures related to referral denials, the following recommendations could further address coordination issues:

2. Purchasers should encourage health plans to allow specialist PCPs for chronically ill members. Public purchasers could pay extra for specialist PCPs for members with specific illnesses.

C. Informing Patients of All Options

In addition to recommendations in the Standardization paper regarding disclosure of information in Evidence of Coverage and other documents and in the Consumer Information, Communication, and Involvement paper regarding disclosure about medical groups' networks, the following recommendations could further address information issues:

3. Require physicians, facilities and medical groups to disclose to patients upon request the number and outcomes of prior procedures performed.

D. Financial Incentives

Recommendations related to financial incentives are included in the Task Force paper on Provider Financial Incentives. *There may remain an issue about how specific the disclosure requirement of capitation and other financial arrangements should be.*

E. Physician Availability

In addition to recommendations in the Risk Avoidance paper regarding risk adjustment , the following recommendations could further address physician availability issues:

4. Require appropriate disclosure and supervision of the use of physician extenders. For example, require minimum physician supervision (e.g., 20 hours per week) in each office site. Require disclosure of whether an appointment is with a physician or physician extender and patient consent, (e.g., indicated by signing a chart).

F. Quality Improvement Programs

In addition to recommendations in the Streamlining paper regarding consolidation of quality auditing, the following recommendations could further address quality improvement issues:

5. Make quality studies and quality information readily understandable and available to consumers, such as by continued efforts of NCQA HEDIS and recent efforts by the Foundation for Accountability and the Pacific Business Group on Health.

PHYSICIAN-PATIENT RELATIONSHIP
BACKGROUND PAPER

I. INTRODUCTION

The physician-patient relationship is fundamental to health care delivery. Indeed, *Consumer Reports* found readers were most satisfied when they liked their doctors, had a choice of physicians, and were happy with their doctor-patient relationship.[19] Cardinal Bernardin, in a statement given to the American Medical Association House of Delegates in 1995, shortly before his death from pancreatic cancer, described the physician-patient relationship as a covenant. He stated:

> The moral center of the doctor-patient relationship is the very essence of being a doctor. It also defines the outlines of the covenant that exists between physicians and their patients, their profession, and their society. The covenant is a promise that the profession makes – a solemn promise – that it is and will remain true to its moral center. In individual terms, the covenant is the basis on which patients trust their doctors. In social terms, the covenant is the grounds for the public's continued respect and reliance on the profession of medicine.[20]

The physician-patient relationship is multi-faceted, making an understanding of the impact of managed care difficult. In addition, physicians are not the only providers who may have a significant relationship with a patient. The issues discussed in this paper are not exhaustive and may be applied to all appropriately-licensed health professionals, operating within their scope of practice.

II. SIGNIFICANCE

There is little empirical evidence of the effect of the physician-patient relationship on outcomes. However, several studies have indirectly attempted to establish a link. For example, Weiss and Blustein studied, in 1991, the impact of duration of relationship among a large, nationally representative sample of elderly patients and their physicians on the processes and costs of medical care and found that longer duration of relationship was associated with substantially lower costs of inpatient and outpatient care and with a lower risk of hospitalizations.[21] Weiss and Blustein also cite numerous other studies that suggest additional benefits of sustained physician-patient relationships, including greater satisfaction among patients, physicians, and other staff; fewer and/or shorter hospitalizations; fewer broken appointments; decreased use of laboratory tests; and decreased use of emergency rooms for care. In addition, increased patient disclosure of personal problems and better compliance with physician instructions have been reported.[22]

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[19] Consumers Union of the US, Inc. "How Good is Your Health Plan? Part One of a Two-Part Report", Consumer Reports, August 1996.
[20] Cardinal Bernardin J, "Renewing the Covenant with Patients and Society", Address to AMA House of Delegates, Washington, DC, December 5, 1995.
[21] Weiss L and Blustein J, "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on Costs and Use of Health Care by Older Americans", *American Journal of Public Health*, 86:12, December 1996, 1742-1747.
[22] Op Cit., Weiss and Blustein, 1996.

Evidence also suggests that patient involvement impacts patients' attitudes about their illness and recovery. Brody et al. studied adult primary care patients in a health maintenance organization (HMO) population to explore the impact of patients' perceptions about the roles they played during medical visits, and found that self-reported "active" patients reported less discomfort, greater alleviation of symptoms, and more improvement in their general medical condition than did "passive" patients. Active patients also reported less concern with their illnesses, a greater sense of control of their illnesses, and more satisfaction with their physicians.[23]

There is also some evidence about the impact of external factors on the physician-patient relationship. One recent study suggests that the availability of a choice of health plans impacts satisfaction with physicians. Preliminary data from the 1997 Kaiser/Commonwealth National Health Insurance Survey found that 18% of those enrolled in managed care with no choice of plan are dissatisfied with their physicians, compared with 13% of those enrolled in managed care with a choice of plans.[24] The historic position of HMOs was that patients should have a choice because they did not want to treat patients who did not choose to be treated by that physician.[25]

III. HISTORY

Views of physicians and patients as well as physician-patient relationships have evolved over time. The traditional view of the physician-patient relationship stems from Plato. He distinguished between "slave medicine" and "medicine befitting free men": "Thus he [the physician] learns something from the sufferers...He does not give prescriptions until he has won the patient's support, and when he has done so he steadily aims at producing complete restoration to health by persuading the sufferer into compliance..."[26]

A. Physicians: From Parent/Teachers to Strangers

In 1935, Henderson described the doctor-patient relationship as a social system, stressing the importance of using the patient's sentiments in modifying behavior and of making it clear that the physician is concerned exclusively with the patient's welfare.[27] In 1951, Parsons viewed the patient as helpless and in need of help, with an obligation to want to get well and to obtain help in doing so, while the physician was held responsible by society for helping the patient recover, by applying the technical resources at his disposal.[28] In 1963, Bloom questioned the assumption that the physician acts entirely as a rational professional and concluded that social and emotional

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[23] Brody DS, et al., "Patient Perception of Involvement in Medicare Care: Relationship to Illness Attitudes and Outcomes", *Journal of General Internal Medicine*, 4, November/December, 1989, 506-511. Also see Greenfield S, et al., "Expanding Patient Involvement in Care: Effects on Patient Outcomes", *Annals of Internal Medicine*, 102, 1985, 520-528 and Greenfield S, et al., "Patients' Participation in Medical Care: Effects on Blood Sugar Control and Quality of Life in Diabetes", *Journal of General Internal Medicine*, 3, Sept/Oct, 1988, 448-457.

[24] Davis K, "Employees Lack Options Among Health Plans", The Commonwealth Fund, August 1997.

[25] Somers AR, *The Kaiser-Permanente Medical Care Program*, New York: Commonwealth Fund, 1971.

[26] Siegler M, "Humanities in Medicine: Falling Off the Pedestal: What Is Happening to the Traditional Doctor-Patient Relationship?", *Mayo Clinic Proc*, 68, 1993, 461-467.

[27] Henderson, LJ, "Physician and Patient as a Social System", *The New England Journal of Medicine*, 212, May, 1935, 819-823 as described in Ford AB, et al, *The Doctor's Perspective: Physicians View Their Patients and Practice*, Cleveland: The Press of Case Western Reserve University, 1967.

[28] Parsons, T, *The Social System*, Glencoe, IL: The Free Press, 1951, as described in Ford, 1967.

factors are important.[29] Also in 1963, Wilson compared the roles of physician and patient to parent and child, priest and supplicant, and teacher and student.[30]

In the last 30 years, the physician-patient relationship, though also shaped by social, political, legal and economic forces, has remained largely paternalistic and proscriptive. However, more recently there has been a shift toward greater communication between physician and patients. In 1980, Siegler offered a model of doctor-patient accommodation that respected the autonomy of both physician and patient and relied heavily on communication, discussion and negotiation.[31] In 1984, Siegler with Childress developed two new models of physician-patient relationship: "medicine of friends" which relies on trust rather than control, and "medicine of strangers", in which rules, procedures, and guidelines become important. They concluded that during the 1980s analysts and regulators treated physician-patient encounters as if medicine were a practice among strangers rather than friends. In 1993, Siegler saw the economic and decision-making power in medicine as having shifted from those who provide medical care and those who receive such care, to those who pay for that care.[32]

The Task Force heard testimony from one physician who complained that physicians are unhappy about managed care and warned of a deterioration in the physician-patient relationship and ultimately in the quality of care.[33] One study of physician satisfaction found that managed care is not uniformly associated with lower levels of satisfaction.[34] Physicians practicing medicine under managed care perceived lower levels of autonomy in patient selection and time allocation measures, but higher levels of autonomy is hospital care, tests, and procedures.

B. Erosion of Trust

Trust is fundamental to the physician-patient relationship, and some suggest trust is undermined by managed care.[35] Gray, however, suggests that skepticism about trustworthiness of doctors, especially under traditional, unmanaged, fee-for-service indemnity and Blue Cross, Blue Shield ("indemnity") medicine, has a long history. He writes

> "For both patients and payers, trust in the competence and fiduciary ethic of physicians and health care institutions has been strained in recent decades by exploding health care costs, accompanied by much publicity about malpractice crises, fraud and abuse, inexplicable variations in patterns of care and high levels

[29] Bloom, SW, *The Doctor and His Patient: A Sociological Interpretation*, New York: Russell Sage Foundation, 1963, as described in Ford, 1967.
[30] Wilson, RN, "Patient-Practitioner Relationships", in HE Freeman, S Levine and LG Reeder eds., *Handbook of Medical Sociology* Englewood Cliffs, NJ: Prentice-Hall, 1963, as described in Ford, 1967.
[31] Op Cit., Siegler M, 1993.
[32] Op Cit., Siegler M, 1993.
[33] Goodson B, Public Hearing Testimony to the Managed Health Care Improvement Task Force, Sacramento, CA, July 11, 1997.
[34] Baker LC and Cantor JL, "Physician Satisfaction Under Managed Care", Health Affairs, 1993 Supplement, 258-270.
[35] Gray B, "Trust and Trustworthy Care in The Managed Care In The Managed Care Era", *Health Affairs*, 16:1, January/February 1997, 34-49; and Gray B, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*, Cambridge: Harvard University Press, 1991.

> of inappropriate services, and an efflorescence of medical commercialism and conspicuous conflicts of interest.[36]

Managed care, he suggests, has added sources of doubt in the trustworthiness of physicians by reducing physicians' autonomy, introducing compensation arrangements that may create conflicts of interest and divide physicians' loyalties, forcing external parties into the doctor-patient relationship and implementing rules that limit the alternatives that doctors can offer patients.

IV. CONTINUITY WITH PHYSICIAN

A continuous relationship with a physician provides familiarity with patient medical histories. As a result, doctors can react quickly in emergencies, make knowledgeable decisions, and handle many situations on the telephone. In addition, studies have shown that patients staying with the same physician for long periods are less likely to be hospitalized, more likely to have lower costs, and to be more satisfied.[37] Many HMOs attempt to formalize this relationship through the designation of primary care physicians (PCPs). Physician assistants and advanced practice nurses, such as nurse practitioners and nurse midwives, may also be designated as PCPs.[38]

Many continuity problems are general health care issues, rather than managed care issues, although increased competition has exacerbated the problems. For example, Americans rarely maintain the same physician for a lifetime. Physicians move, patients move, needs change and preferences change. Theoretical free choice under indemnity coverage was also limited by lack of information, travel time, distance, and price.

A. Closed HMO Panels

A defining feature of HMOs is selective contracting with physicians, physician groups and IPAs on the basis of quality and price. Selection allows HMOs to contract with appropriate numbers and types of physicians while negotiating payment rates. With selective contracting, member choice of physician is most dependent upon choice of HMO. Thus, members of closed-end HMOs may be unable to continue with their current doctor when joining a new plan. However, California medical practices had an average of 15 managed care contracts in 1995,[39] so many physicians are available through several HMOs. Nevertheless, 45% of Californians who receive coverage through their employer do not have a choice of plans (excluding choices through spouses' employers).[40] (See Expanding Consumer Choice paper).

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[36] Op Cit., Gray B, 1991.

[37] Weiss LJ, Blustein J, "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans", *American Journal of Public Health*, Volume 86, pp. 1742-7, 1996; and Blumenthal, D, et al;, "The Efficacy of Primary Care for Vulnerable and Other Population Groups", *Health Services Research*, 30, 1995, 253-273.

[38] 1994 GHAA Survey indicated that approximately 70% of plans use these providers as PCPs. Dial T, et al., "Clinical Staffing in Group and Staff Model HMOs", *Health Affairs*, Summer 1995.

[39] *Physician Marketplace Statistics 1996*, American Medical Association, Center for Health Policy Research, Chicago, 1996.

[40] Kelly Hunt, KPMG Peat Marwick, Analysis conducted for the California Managed Health Care Improvement Task Force, Tysons Corner, VA: 1996.

B. Termination of Physician Contract

HMOs may terminate physician contracts at any time without cause, as may the medical groups or IPAs with which HMOs contract. When terminations occur, patients may be forced to change physicians, sometimes in the middle of their contract period. Typically, the earliest time at which an enrollee may attempt to change health plans to recover a physician relationship is at the next open enrollment. If their employers do not offer a choice of plan, patients may not have the opportunity to stay with the same doctor. Information regarding the prevalence of termination without cause in largely unavailable. Physicians terminated for economic reasons rather than quality reasons often feel that the decision was unjust, as do their patients, who often feel greater allegiance to their physician than to their health plan. Currently, Knox-Keene regulated health plans must disclose the reasons for termination (or specific reasons if terminated for quality of care reasons) to the provider if the termination occurs during the contract year but not upon non-renewal of a contract.[41] Popular medical groups cannot be easily terminated without the health plan losing customers.

In an attempt to provide greater continuity of care, the federal Advisory Commission on Consumer Protection and Quality in the Health Care Industry issued a preliminary recommendation to require plans to provide for consumers who are undergoing a course of treatment for a chronic or disabling condition (or who are in the second or third trimester of a pregnancy) at the time they involuntarily change plans or a provider is terminated by a plan for reasons other than just cause to continue seeing their current specialty providers for up to 60 days (or through completion of post-partum care).[42] In a more decisive step, at least one California health plan, in response to a requirement established by CalPERS, relinquished some negotiating power in order to insist that contracts with its medical groups provide for 18 months of continuity for enrollees in the event of contract termination.[43]

C. Changes in Coverage by Employer

Employers may change health plans or coverage to lower costs as frequently as each year. While employee resistance and administrative costs keep changes in check, such change is not uncommon.[44] When employers change or eliminate coverage, patients may be forced to select a plan that does not include their current physicians.

D. Lack of Choice and Information

Consumers have never had adequate objective, comparative information for selecting doctors. Rather, many people rely on opinions of friends, family and other doctors. Though still in its infancy, managed care has driven the production of comparative data to inform consumers (See Consumer Information, Communication and Involvement paper).[45] For individuals choosing a

[41] Knox-Keene Act, Section 1373.65.
[42] Advisory Commission on Consumer Protection and Quality in the Health Care Industry, "Chapter Two: Choice of Providers and Plans", preliminary draft, October 13, 1997.
[43] Personal interview, October 1997.
[44] Lipson D, De Sa J, "Impact of Purchasing Strategies on Local Health Care Systems," *Health Affairs*, 15:2, Summer 1996, 62-76.
[45] Gray B, "Trust and Trustworthy Care in the Managed Care Era," *Health Affairs*, 16:1, January/February 1997, 34-49.

new primary care physician, choice can be limited by physician capacity to accept new patients. Often, members are unaware of these constraints until after plan selection.

V. 'GATEKEEPER' ROLE OF PRIMARY CARE PHYSICIAN AND UTILIZATION REVIEW

Based on the United Kingdom's general practitioner, the intention of the PCP is to improve quality and reduce costs by coordinating specialty visits, procedures and pharmaceuticals. For example, pharmaceuticals prescribed by different specialists should be checked for interactions and the relationship between different conditions addressed. The gatekeeping requirement reduces costs by eliminating duplication and reducing the intensity of services through decreasing use of laboratory, specialty, and emergency room services.[46]

Studies show that an estimated 14% to 32% of procedures are unnecessary.[47] PCPs are responsible for determining what care is necessary and denying patients access to unnecessary care. This aspect of gatekeeping can strain physician-patient interaction.[48] This problem is most likely among patients such as the chronically ill who are accustomed to using specialty care and emergency services and for whom the gatekeeper requirement may require some duplication of visits. Studies suggest that chronically ill patients are less likely than healthy patients to be satisfied with plans that restrict their choice of physician.[49]

Most HMOs in California delegate much or all of the financial risk of caring for patients to the IPAs or medical groups with which they contract.[50] These groups (and the HMOs where they have not delegated the risk) also control utilization through some combination of prior, concurrent, and retrospective review processes. Some studies have shown that utilization review reduces inpatient costs,[51] but questions remain about whether it reduces societal costs.[52] Medical group or plan level decisions may contradict physician decisions and patient desires. As a result, experience with prior authorizations has contributed to a negative opinion of managed care. Despite antagonism to utilization review, capitated physician groups rely on these techniques to roughly

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[46] Moore SH, et al., "Does the Primary Care Gatekeeper Control the Costs of Health Care?", *The New England Journal of Medicine*, 309:22, 1983, 1400-1404; and Blumental D, et al., "The Efficacy of Primary Care for Vulnerable and Other Population Groups", *Health Services Research*, 30, 1995, 253-273.

[47] Sui AL, et al., "Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans", *The New England Journal of Medicine*, November 13, 1986, 1259-1266; Chassin MR, et al., "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? A Study of Three Procedures", *Journal of the American Medical Assocation*, November 13, 1987, 2533-2537; and Winslow DM, et al., "The Appropriateness of Performing Coronary Artery Bypass Surgery", *Jounral of the American Medical Association*, July 22, 1988, 505-509.

[48] Blumenthal, D, "Effects of Market Reforms on Doctors and Their Patients", *Health Affairs*, Summer 1996, 170-184.

[49] Blendon R, "All Payer, Single Payer, Managed Care, No Payer: Patients Perspectives in Three Nations", Health Affairs, 15:2, Summer 1996, 255-265.

[50] California Association of HMOs, *1997 Profile*, 1997, p.21.

[51] Feldstein PJ, et al., "The Effects of Utilization Review Programs on Health Care Use and Expenditures", *The New England Journal of Medicine*, 318:20, 1988, 1310-1314.

[52] Rosenberg SN, et al., "Effect of Utilization Review in a Fee-for-Service Health Insurance Plan", *The New England Journal of Medicine*, 333:20, 1995, 1326-1330.

the same extent as do other types of organizations.[53] Some studies have shown that utilization review organizations with high levels of physician control were particularly willing to interfere with practicing physicians' autonomy by questioning or denying authorizations.[54]

In addition, the referral process is new to many physicians, is often clumsy, and needs further improvement. Patients may question denials because they are not used to limitations, are suspicious of financial incentives, have no personal incentive to economize, and unrealistically high expectations of health care.[55] While denials of unnecessary care are appropriate, PCPs do not always communicate the rationale for their decisions effectively with their patients. Many denials fall within a gray area, and some patients may be denied medically necessary care.

In order to address patient demand for broader access, many HMOs have developed new plans types. For example, some plans allow members to see a specialist without a referral within their PCP's medical group for a higher copayment. In addition, Point-of-Service (POS) plans allow patients to see out-of-network physicians after payment of a deductible and copayment.

A. Controlling Access to Specialists

A defining feature of most HMOs is that PCPs initiate referrals to specialists. As a result, the scope of services many PCPs provide has expanded, causing some discomfort among PCPs and specialists alike about whether primary care gatekeepers are encouraged or required to practice outside their scope of competence, especially when gatekeepers also face financial incentives to restrict use of services.[56,57]

Patients and PCPs may disagree about the need for a specialist. In addition, HMO utilization review committees may disagree with both doctor and patient.

Another defining feature of HMOs is risk sharing. For example, many HMOs pay the PCP's medical group for all professional services. The medical group may then restrict most care to that medical group. Patients may not understand these restrictions during open enrollment. Alternatively, an HMO may deny or delay referrals requested by a patient's PCP. Although some denials may be in patients' best interests, HMOs and PCPs may also deny necessary care.

The Task Force's survey of literature on the public's perception found that time required to approve care is a consistent source of dissatisfaction across all types of plans. One 1994 national telephone study found lower satisfaction among managed care patients with some aspects of

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[53] American College of Physicians, "The Oversight of Medical Care: A Porposal for Reform", *Annals of Internal Medicine*, 120:5, 1994, 423-431; PPRC, *Annual Report to Congress*, 1995.
[54] Schlesinger M, Gray B, and Perreira K, "Medical Professionalism Under Managed Care: The Pros and Cons of Utilization Review", *Health Affairs*, 16:1, January/February 1997, 106-124.
[55] "President's Message on the State of the Union", *The New York Times*, January 26, 1994, A16.
[56] Op-Cit., Blumenthal, D, 1996; and Ayanian JZ, et al., "Knowledge and Practices of Generalist and Specialist Physicians Regarding Drug Therapy for Acute Myocardial Infarction", *The New England Journal of Medicine*, 318:20, 1988, 1310-1314.
[57] Center for Studying Health System Change and Mathematica Policy Research Inc., nationwide survey of physicians.

specialty care , but higher satisfaction than indemnity plan patients with the speed of referrals to specialists.[58] (See Task Force paper on Observations of the Public's Perceptions).

B. Specialist to Specialist Referrals

When a patient's specialist decides that an additional referral is necessary, many HMOs require the PCP to generate that referral. As above, the intention is to coordinate care and prevent unnecessary expenditures. Patients may perceive PCP involvement as unnecessary bureaucracy, and their specialists may reinforce this perception. Furthermore, PCPs may disagree with specialists about needed care.

In one innovative response to physician and patient complaints about specialist referral restrictions, an out-of-state health plan has organized specialty teams that agree to follow agreed-upon treatment protocols. The plan pays the specialty teams a predetermined case rate for all care related to a particular illness or condition.[59] The PCP must only make the initial referral to the specialty team, and the team makes further medical decisions without PCP authorization.

C. Denying Unnecessary Procedures/Tests

Part of a physician's role is informing patients when tests are "medically necessary" and when they are not. For example, if a pregnant woman requests an ultrasound that is not medically indicated, the procedure should not be covered. Some have described perceived and actual instances of HMOs denying necessary care, which has resulted in patient feelings of mistrust.[60] Non-disclosure of payment and risk-sharing arrangements has augmented suspicion and distrust of care denials.[61] This mistrust impacts the physician-patient relationship as described above.

D. In-Network vs. Out-of-Network Providers

HMOs often pay medical groups and IPAs a fixed periodic rate per-member-per-month (i.e., capitation) for all professional services, creating an incentive to provide most care within the group. However, a patient or provider may feel that the best provider is outside the group, or even outside the network, and want the HMO or medical group to pay the cost. Often such out-of-network referrals make sense because appropriate care can also costs less. However, the PCP may disagree with a patient that an out-of-network referral is necessary.

VI. INFORMING PATIENTS OF ALL OPTIONS

Managed care expects patients to play a more participatory role in their care. Thus, under managed care, patient access to more and better information for patients is appropriate and necessary. The increasing use of the Internet for medical information reflects this need.[62] Health plans should not constrain physicians from presenting all treatment options to their patients.

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[58] Op Cit., Blendon, et al., p.46.
[59] Louise Kertesz, "Organizing Specialists," *Modern Healthcare*, August 25, 1997, 33.
[60] Mechanic D, Schlesinger M, "The Impact of Managed Care on Patient's Trust in Medical Care and Their Physicians," *JAMA*, 275:21, June 5, 1996, 1693-97.
[61] Op Cit., Gray, Jan/Feb 1997.
[62] Stolberg SG, "Ideas & Trends; Now, Prescribing Just What the Patient Ordered," *The New York Times*, August 10, 1997, Section 4 (Week in Review), Page 3, Column 1.

Rather, physicians should feel obligated to help patients to make informed decisions based on the advantages and disadvantages of each option and the patient's personal preferences.

A. "Gag Clauses"

Some HMOs require physician confidentiality about proprietary plan information in their contracts; far fewer, if any, restrict physician-patient discussion about treatment options.[63] California and federal legislatures have banned the latter, so called, "gag clauses". In addition, according to the US General Accounting Office, contract provisions may not have a significant impact on physician practice because physicians do not carefully read their contracts with HMOs. Physicians reported that they freely communicate with their patients regarding all medically appropriate care because habitual practice, professional ethics, and fear of medical liability are stronger influences on their behavior than contract requirements. However, fear of termination by HMOs can bring significant pressure on physicians to modify their practice patterns or discussions with patients, without gag clauses.[64] Both actual and perceived limitations can hurt the doctor-patient relationships by reducing trust and openness.

B. Disease Management and Guidelines

Disease management is a systematic approach to treating chronic diseases which has been applied by HMOs and other managed care organizations.[65] To care for the chronically ill, HMOs provide clinical guidelines, patient education, physician education, monitoring, prevention and outcomes measurement. Used both in disease management programs and general practice, guidelines can contribute to quality of care by reducing unwarranted variation in clinical decision making and by providing physicians with concise, practical advice on the diagnosis and treatment of illness.[66] Most HMOs use guidelines only as recommendations to accommodate differences among patients and their preferences as is appropriate since the individual needs of each patients should ultimately determine appropriate care. In practice, studies suggest that guidelines have limited ability to change physician behavior.[67] However, some physicians may perceive guidelines as fixed constraints because they fear being an outlier.

C. Not All Providers are Alike

Not all providers have the same capabilities or experience. Studies have demonstrated that certain procedures are volume sensitive; the greater the experience of performing the procedure, the better

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[63] US General Accounting Office, "Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, But Physician Concerns Remain" (GAO/HEHS-97-175), August 1997. The study found, out of 529 HMOs, none used contract clauses that specifically restricted physicians from discussing all appropriate medical options with their patients. The study also found that 62% of plan contracts required physicians to maintain the confidentiality of proprietary information including the plan's payment and incentive structure, medical management criteria, and clinical practice protocols. However, 70% of these contracts also included "anti-gag clauses" which state that providsions in the contract are not to be construed as prohibiting discussions of care related matters with patients. The study found fewer instances of nondisparagement (of health plan) and nonsolicitation (to another health plan) clauses, many of which were also accompanied by anti-gag clauses.

[64] Ibid.

[65] Epstein and Sherwood *Annals of Internal Medicine* Volume 124, Number 832, 1996.

[66] Blumenthal D and Scheck A, eds. *Improving Clinical Practice: Total Quality Management and the Physician*. San Francisco: Jossey-Bass, 1995.

[67] Yandell B, "Critical Paths at Alliant Health System" *Quality Management in Health Care*, 3:2, 1995, 55-64.

that risk adjusted outcomes.[68] The current system lacks a systematic mechanism for assessing and informing patients about the experience and competence of their health care delivery system and personal physician.[69] In recognition of the variation among providers, the federal Advisory Commission on Consumer Protection and Quality in the Health Care System has made a preliminary recommendation to require physicians and facilities to disclose to patients upon request their experience in certain procedures.[70]

VII. FINANCIAL INCENTIVES

While physicians are motivated principally by professional ethics and desire for the esteem of their peers, they also face financial incentives. All compensation arrangements contain incentives which may have positive and negative effects. An important issue is whether or not patients have access to information about how their medical care is paid for (see Provider Financial Incentives paper). Several forms of compensation in managed care arrangements shift financial risk for caring for patients to providers. If undisclosed and too intense, these financial arrangements can create pressure to deny medically necessary care. Putting providers at risk for the cost of care puts treatment decisions in doctors' hands, where most people agree they belong (though some say this creates a conflict of interest), as long as doctors consider patient preferences and patients know and understand the financial incentives their physicians and medical groups experience.[71] Often, these decisions are not easy and cause discontent. Also, physicians serving as medical directors may also encourage other physicians to deny services.[72]

Low patient copayments in HMOs may strain doctor-patient relationships. With low copayments, patients' financial obligation is limited and their interest in cost-effectiveness of care may be reduced. In contrast, many HMO physicians bear some financial risk and thus have an incentive to reduce unnecessary services. In testimony to the Task Force in Fresno, one physician explained that the reason he did not like managed care was because it made him and his patients adversaries.[73] He used an example of a patient who wanted an ultrasound which he denied as unnecessary. In contrast, if his patient were instead required to pay for the same test, she might have been grateful to him for saving her the expense.

A. Capitation and Risk

The UK introduced capitation of PCPs to provide a simple payment system for budgeting without motivating overuse. In this country, Henry J. Kaiser adopted capitation when he paid fixed sums per-patient-per-month to Dr. Sidney Garfield.[74] Mr. Kaiser had a predictable, controllable outlay, and Dr. Garfield had maximum freedom to allocate resources effectively.

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[68] Phillips KA, Luft HS, Ritchie, JL, "The Association of Hospital Volumes of Percutaneous Transluminal Coronary Angioplasty With Adverse Outcomes, Length of Stay, and Charges in California," *Medical Care*, 33:5, May 1995, 502-514.

[69] Ezekiel EJ and Dubler NN, "Preserving the Physician-Patient Relationship in the Era of Managed Care," *JAMA*, 273:4, January 25, 1995, 323-329.

[70] Advisory Commission on Consumer Protection and Quality in the Health Care Industry, "Chapter One: Information Disclosure", October 13, 1997.

[71] Op Cit., Gray, Jan/Feb 1997.

[72] Op Cit., Gray, Jan/Feb 1997.

[73] Public Hearing testimony to the Managed Health Care Improvement Task Force, Fresno, CA, June 20, 1997.

[74] Somers AR, *The Kaiser-Permanente Medical Care Program*, New York: Commonwealth Fund, 1971.

Capitation creates incentives to prevent diseases, diagnose early, and treat illness effectively. In general, denying necessary care increases costs in the long run. In addition, capitation offers the flexibility to introduce innovative programs, such as fall prevention and patient education. Capitation, however, may also create pressure to provide less care than needed. In particular, if capitation payments are not risk-adjusted, groups may lose money on sicker patients (See Risk Avoidance Task Force paper). To compensate, some capitated medical groups and small IPAs purchase stop-loss insurance for the most expensive cases.

Equally important, the introduction of capitation may also have changed patients' perceptions of their physicians and their motives. Blumenthal suggests that this could lead to a generalized loss of trust in the medical profession and reduced satisfaction on the part of both patients and physicians.[75] Many patients and physicians are uncomfortable trading off costs and benefit, and are concerned that capitation may affect physician ethics by creating undisclosed conflicts of interest.

B. Risk Pools

Physician bonuses and withholds were developed to encourage cost-effective practice by physicians paid fee-for-service or salary, and to put capitated groups at risk for quality and patient satisfaction. Most groups limit bonuses and withholds to a small portion of physician income, and both federal law[76] (applicable to Medicare and Medicaid patients) and state law[77] prohibit arrangements that are an inducement to limit or reduce necessary services to an individual enrollee. However, inappropriate risk-sharing arrangements may exist, and other incentive schemes are poorly understood.

VIII. PHYSICIAN AVAILABILITY

When people are sick, they want to see their doctor and expect their doctor to be available; they want appointments to be available within a reasonable time frame, and to be long enough for evaluation and treatment. One study suggests that 46% of CalPERS members who switched health plans because of long appointment delays felt that one to six days was too long to wait for an appointment.[78] Similarly, 52% who switched because of long waits at the physician's office felt that 30 minutes or less was too long to wait. Other studies have shown that patients on average make more visits in HMOs than in indemnity plans.[79]

Adequate physician availability can prevent miscommunication, non-communication, disputes, and grievances. Current law regulating Knox-Keene health care service plans theoretically restricts physician panels to 2,000 patients per PCP.[80] Availability, however, may depend on the physician

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[75] Op Cit., Blumenthal D, 1996.
[76] Sections 4204(a) and 4731, OBRA 1990, Public Law 101-508; and HCFA Regulations 42CFR, Section 417.479.
[77] AB 2649, 1996, now part of Knox-Keene Act Section 1367.10.
[78] California Public Employees' Retirement System, *1995 Open Enrollment Exit Survey: Final Report for Basic Health Plans*, Sacramento, CA, April 16, 1996.
[79] Mark T, Mueller C, "Access To Care In HMOs And Traditional Insurance Plans," *Health Affairs*, Volume 15, Number 4, Winter 1996, pp. 81-87.
[80] Item H(i) Primary Care Providers in Commissioner's Rule 1300.51(d) in Title 10, California Code of Regulations.

and the patient panel. It would be relatively easy for an individual physician to provide 2,000 healthy people with access, but nearly impossible if all the 2,000 were seriously ill. In addition, some doctors are better at building relationships with patients than others are. One doctor can consistently satisfy patients in 10 minutes, while another can fail in 30 minutes.

A. Inadequate Visit Time

Physician visits are needed to discuss, diagnose and recommend treatment. Physician visit time may be inadequate under any model health plan. For example, one could argue that physicians paid on a fee-for-service basis have an incentive to reduce visit time in order to provide more. Under managed care, as under any type of health plan, physicians may be encouraged or required to see more patients, resulting in less time per visit.

In response to shorter visits, some patients may organize questions in advance, and others may not ask questions at all. Some patients may not be able to clarify instructions, with adverse medical consequences. In addition, patients may feel short-changed because they are accustomed to longer visits. Patient feelings of dissatisfaction, whether due to perceived or actual problems, are valid and can damage the doctor-patient relationship. In 1995, 7% of PBGH HMO members, 9% of POS members and 3% of PPO/indemnity members felt dissatisfied with the length of time their doctors spent with them during visits.[81]

B. Appointment Availability

Similarly, if appointment availability does not meet patients' expectations, patients may feel that accessibility is not meeting their medical needs. For example, when PCPs accept large patient panels, patients may need to wait longer for appointments. In 1995, 17% of PBGH HMO members, 19% of PBGH POS members, and 12% of PBGH PPO/indemnity members felt that, the last time they visited the doctor, they could not get an appointment at a time that was convenient for them.[82]

However, a national access survey sponsored by the Robert Wood Johnson Foundation, suggests that HMOs provide better access to appointments by some measures: 13% of HMO enrollees reported waiting over 30 minutes compared to 17% of PPO enrollees and 20% of indemnity enrollees.[83] In addition, 85% of HMO enrollees reported a medical visit within the past year, compared to 80% of indemnity enrollees, and HMO members with a visit averaged 4.8 per year, compared to 4.0 for indemnity.

C. Physician "Extenders"

To reduce expenses, managed care organizations often replace more expensive resources, such as physicians, with less expensive resources.[84] For example, advice nurses offer 24-hour service for

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[81] Pacific Business Group on Health, *Health Plan Value Check*, June 1996.
[82] Ibid.
[83] Mark T, Mueller C, "Access To Care in HMOs and Traditional Insurance Plans," *Health Affairs*, 15:4, Winter 1996, 81-87.
[84] Felt-Lisk S, "How HMOs Structure Primary Care Delivery," *Managed Care Quarterly*, 1996; 4(4), 96-105.

many HMO members, and advanced practice nurses are staffing patient clinics.[85,86] Some patients prefer nurse practitioners and midwives, finding them more compassionate or informative than physicians. Often, physician extenders have been communication skills than physicians do. In addition, because of physician extenders, some physicians have more time for patients. However, some physicians argue that physician substitution has resulted in inadequate follow-up, coordination, and oversight.

D. Developing Doctor-Patient Relationships

Doctor visits have both medical and emotional impact. If physicians and patients spend less time together, they may have difficulties building relationships.[87] Patients may feel frustrated if their physician does not know them well or does not ask about their personal life. As a result, shorter visits that may be medically acceptable can still be a source of patient dissatisfaction.

IX. QUALITY IMPROVEMENT PROGRAMS

Purchasers have largely driven quality measurement and improvement efforts. While not universal and still under development, these quality measurement efforts offer feedback to providers to improve and information to purchasers and consumers to judge quality and service. HMOs that testified to the Task Force described quality improvement programs in California that have successfully addressed disease treatment (such as diabetes and asthma) and administrative processes (such as billing).

A. Increased Paperwork

The paperwork to support quality programs requires the investment of significant time and resources, though this load may be reduced as more electronic data becomes available. While the cost in hours is readily apparent to those required to provide the data, the benefit of quality measurement activities may not always be. In addition, as reported in the Task Force Streamlining paper, a variety of organizations require or conduct duplicative quality audits and studies which is clearly wasteful.

B. Disclosure of Quality Results

Several have noted that trust in physicians' decisions is increasingly being supplemented by evidence.[88] Blumenthal suggests that quality research efforts and the sharing of results with patients could "powerfully reinforce and complement the professional ethic of the physician..."[89] This could be particularly important where financial incentives are seen to create potential conflicts of interest for providers. Physician data demonstrating superior performance can boost patients' confidence and trust. However, for results to be valid, quality measures must use standardized definitions and adequate severity adjustment.

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[85] Grandinetti D, "Patient Phone Calls Driving You Crazy? Here's Relief," *Medical Economics*, 73:12, June 24, 1996, 72.
[86] Cimons M, "Health Reform May Expand Role of Advanced Practice Nurses," *Los Angeles Times*, June 28, 1993, A1.
[87] Op Cit., Sigler M, 1993.
[88] Op Cit., Gray B, "Trust and Trustworthy Care" 1997.
[89] Op Cit., Blumenthal D, 1996.

X. RECOMMENDATIONS

A guiding principal for the recommendations of this Task Force and health care system change in general should be an evaluation of the effect of the proposed change on the physician-patient relationship.

A. Continuity with Physicians

In addition to recommendations in the Consumer Information, Communication and Involvement paper regarding disclosure and presentation of information about provider availability, the following recommendations could further address continuity issues:

1. The regulatory authority should require health plans and medical group/IPAs to write contractual arrangements that enable members such as those chronically ill, acutely ill, and pregnant to continue seeing their doctors until the end of the patients' contract year and no less than a minimum period such as 60 days or through completion of post-partum care.

In addition, there may also be an issue regarding whether or not plans should be required to provide a reason for non-renewal of a provider's contract without cause.

B. 'Gatekeeper' Role of Primary Care Physician and Utilization Review

In addition to recommendations in the Medical Necessity paper regarding modification of prior authorization procedures and in the Dispute Resolution paper regarding disclosure and procedures related to referral denials, the following recommendations could further address coordination issues:

2. Purchasers should encourage health plans to allow specialist PCPs for chronically ill members. Public purchasers could pay extra for specialist PCPs for members with specific illnesses.

C. Informing Patients of All Options

In addition to recommendations in the Standardization paper regarding disclosure of information in Evidence of Coverage and other documents and in the Consumer Information, Communication, and Involvement paper regarding disclosure about medical groups' networks, the following recommendations could further address information issues:

3. Require physicians, facilities and medical groups to disclose to patients upon request the number and outcomes of prior procedures performed.

D. Financial Incentives

Recommendations related to financial incentives are included in the Task Force paper on Provider Financial Incentives. *There may remain an issue about how specific the disclosure requirement of capitation and other financial arrangements should be.*

E. Physician Availability

In addition to recommendations in the Risk Avoidance paper regarding risk adjustment , the following recommendations could further address physician availability issues:

4. Require appropriate disclosure and supervision of the use of physician extenders. For example, require minimum physician supervision (e.g., 20 hours per week) in each office site. Require disclosure of whether an appointment is with a physician or physician extender and patient consent, (e.g., indicated by signing a chart).

F. Quality Improvement Programs

In addition to recommendations in the Streamlining paper regarding consolidation of quality auditing, the following recommendations could further address quality improvement issues:

5. Make quality studies and quality information readily understandable and available to consumers, such as by continued efforts of NCQA HEDIS and recent efforts by the Foundation for Accountability and the Pacific Business Group on Health.